



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ORTHOTEXAS PHYSICIANS AND SURGEONS

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-15-4030-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

August 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see attached EOB, HCFA, and documentation for the above date(s) of service. This is our written request for reconsideration. On this date of service, you denied the charges as not timely filed. We file out claims electronically Workcomp EDI is our clearing house. The report will show the day we billed the claim and the day your office confirmed receiving the claim. I have included in the reconsideration the report from our clearing house proving timely filing for your review."

Amount in Dispute: \$156.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the above captioned medical fee dispute resolution. It is our position that it past the one year filing deadline for the provider to request a medical fee dispute resolution."

Response Submitted by: BROADSPIRE PO BOX 14351 LEXINGTON KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 05, 2014	CPT Code 99213 and 99080	\$156.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 18 – Exact duplicate claim/service

- 224 – Duplicate charge
- D10 – The time limit for filing has expired
- P13 – Payment reduced or denied based on Workers Compensation Jurisdictional regulations or payment policies, use only if no other code is applicable
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- D51 – Unnecessary treatment based on peer review
- V – Unnecessary treatment (w/ peer review)
- D00 – Based on further review, no additional allowance is warranted

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the service in dispute is May 05, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 13, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

		9/11/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.